CITY OF RIVERSIDE

November 12, 2008

Mayor Ron Loveridge
Riverside City Council
3900 Main Street
Riverside, CA 92501

RE: Request for Guidance from the Community Police Review Commission

Honorable Mayor and Members of the City Council:

On October 22, 2008, the Community Police Review Commission ("The CPRC or Commission") directed me, as Chair, to send you this follow-up letter concerning their original request for guidance on the September 24, 2008.

Background of Written Request for Guidance

On September 24th, a majority of the Commission[1] voted to direct staff to inform the City Council that they needed guidance regarding the implementation of the City Manager's directive of September 3, 2008 to staff and its application to the Commission in light of City Charter §810(d). The Commission requested guidance from the City Council by majority vote of the Council. Based upon the discussion of the Commission, it was the Commission's intention that this item be agendized by Council (or a sub-committee thereof) so the Commission would have the opportunity to speak on the issue.

In our meeting of October 22, 2008, it became apparent through questions to staff that the Commission's request for guidance of September 24, 2008 was not communicated by its staff in a formal manner, but was communicated informally through the Assistant City Manager. To insure that you received the actual message that was intended to be conveyed by the Commission on September 24, 2008, the Commission, on October 22, 2008, directed its Chair, by a majority vote,[2] to write this letter in an effort to better frame the concerns of the Commission[3] and ensure that an opportunity is provided so it can be discussed by the Council and the Commission.

The Issues in which the Commission Seeks Guidance

Riverside City Charter Section 810 provides the Commission with the power and the duty to "[r]eview and investigate the death of any individual arising out of or in connection with the actions of a police officer, regardless of whether a complaint regarding such a death has been filed." (Emphasis added)

After the Commission's first officer-involved death ("OID") case in 2001, it became the policy of the Commission to initiate their investigation upon their awareness of a death that may have arisen from or been connected with the actions of a Riverside Police Department ("RPD")

officer. This policy was put into place as a result of the Commission's dissatisfaction with the seven-month delay it faced in initiating its first OID investigation. The Commission directed staff to take steps to enlist the services of the Commission's investigator on a timely basis to avoid the loss of evidence (witnesses and memories) due to the passage of time and ensure a thorough and comprehensive investigation.[4]

To avoid allegations that the Commission's investigator was interfering with official law enforcement investigations, it also became the Commission's policy that its investigator was to be dispatched only after staff learned of the death through public reports.[5] This protocol has served the Commission well for over six years, with no reported problem.[6]

On September 3, 2008, the City Manager's Office ("CM") issued a directive to the Commission's staff that the Commission's investigative protocol was being changed. As conveyed to the Commission by staff, the Commission, from that day forward, was to refrain from initiating any future OID investigations until after all criminal investigations by law enforcement have been concluded and the Commission receives the criminal casebook. The rationale provided by the CM for this change was to preclude any possibility that the Commission's review process could jeopardize criminal investigations by the RPD and the Riverside County District Attorney's Office ("RCDA").

The Commission was also notified that City funds were not authorized for use on Commission activities (i.e. investigations) deemed by the City Attorney ("CA") to be outside the Commission's scope of authority.[7]

While concerns have been articulated by members of the Commission and the public that the CM is attempting to control the Commission through directives to staff,[8] the Commission has three concerns to be addressed in this letter. First, the directive is an attempt by the CM / CA to preclude the Commission from investigating deaths that it believes it is obligated to investigate under the Charter by re-defining what it can investigate.[9] Second, regardless of how the first concern is ultimately interpreted and determined to be handled, the directive impairs the Commission's ability to conduct preliminary investigations of potential OIDs to preserve evidence. Finally, the directive has the consequence (unintended or otherwise) of improperly restricting the Commission from conducting its investigations, in a timely manner, into those instances where there is absolutely no question of a police officer's connection with a death, such as when the death is the result of an officer-involved shooting ("OIS")[10] (the vast majority of its OID cases thus far).

<u>Is the Charter language "in connection with" the functional equivalent of "causation" as determined by the Coroner?</u>

There is the question of whether or not the Commission is duty-bound to promptly begin to investigate a death in the rare situation where <u>cause of death</u> is not immediately apparent, but there is some concern (by the Commission or the public) that the death may be <u>in connection with</u> the actions of a police officer. This type of situation occurred for a second time[11] in the Commission's history a few weeks prior to the CM's directive.[12]

This question has lead to the well-publicized disagreement between members of the Commission and the City Attorney as to the Commission's legal ability to apply the "arising out of or in connection with" language of Section 810(d) in such cases.[13]

As interpreted by the CA, the Commission's OID investigation obligation is limited to those situations where the cause of death is immediately known, such as an OIS, or in those instances where causation is not immediately known, only after a causation determination has been made by the Coroner's Office and the Coroner's report identifies the actions of a police officer as a primary or contributing factor to the death.

In essence, the CA is advising the Commission that a cause of death established by the Coroner's Office is the functional equivalent of the "arising out of or in connection with" language of Section 810(d). The Commission has expressed concern that the CA's interpretation of Section 810(d) is narrower than the clear language of that section and it unduly restrains its power and duty to investigate broader matters of concern, such as deaths "connected with the actions of a police officer."

There is nothing in the Charter or the Commission's policies or procedures (written or by custom and practice) requiring cause of death findings by the Coroner's Office to be the official gatekeeper of what falls within or outside the scope of the Commission's authority. It is the Commission's contention that, regardless of the actual determination by the Coroner's Office of an individual's cause of death, the Commission, under this Charter section, does have the power to investigate and there is precedent to support their interpretation.[14]

It is also the Commission's contention that following the CA's interpretation could result in situations where the Coroner's Office's determination of causation may not reference the actions of a police officer, but the Commission's review of the underlying facts may show that a death was "in connection with" the actions of a police officer.[15]

Subsequent to the disagreement with the CA over interpretation, the CM's directive was implemented, which effectively stopped <u>all</u> new Commission investigations from being launched in a timely manner, regardless of whether or not the cause of death was immediately known.

The Commission requests Council's guidance on the Commission's ability to investigate deaths "arising out of or in connection with" RPD officers under Charter Section 810(d) when an individuals cause of death is not immediately apparent and seeks to also have the Council confirm that the Commission's scope of authority as set forth in the Charter is not intended to be the functional equivalent of a Coroner's Office determination of the cause of death.

<u>Does the City Manager's directive apply to "Preliminary Investigations" to preserve evidence, where causation is not yet determined, but relevant evidence may disappear in the interim?</u>

Even if the causation issue in deaths where the cause was not immediately known were to be resolved by a Council decision that a Coroner's Office determination of causation is the functional equivalent of the "arising out of or in connection with" language of the Charter, there is still the issue of what the Commission's duties are pending that determination.

As acknowledged by the CA, in situations where a death occurs and there is an open question as to whether the actual or potential involvement of the actions of a police officer is a consideration, the Coroner's Office will expedite their process, but a final report will still take weeks or months to be produced.[16]

What if the initial indications were unclear or it was reported that the cause of death was not officer-related, but then when the official report does come out it is revealed that an officer's

action(s) was the cause or a contributing factor to the death? How much time must the Commission lose securing the contact information and statements of witnesses?

People are transient in nature and the Commission believes that it has a Charter-mandated duty to not only investigate, but to act responsibly and protect its ability to investigate. A majority of the Commission believes that, in those instances where the cause of death is not immediately apparent, but there are indications that the death may be "arising out of or connected with the actions of a police officer," it is appropriate for the Commission to initiate a "Preliminary Investigation" into the death in an effort to preserve evidence (such as the identification of possible witnesses and their contact information) pending a determination of the cause of death.[17]

It is the Commission's request for Council's guidance as to whether it is appropriate for the CM's directive, as it is currently being applied, to prevent the Commission from conducting Preliminary Investigations to protect and preserve evidence pending a Coroner's office determination.

Should the City Manager's directive apply to situations where connectivity or causation is not an issue or no longer an issue?

As discussed above, the vast majority of OIDs that come before the Commission are OISs. When the OID involves an OIS, there is absolutely no issue as to connection / causation that requires any sort of delay in waiting for a finding or interpretation by the Coroner. However, the Commission is concerned that the CM's directive improperly and unnecessarily prevents the Commission from conducting timely investigation into cases, like OISs, where connectivity or causation is clearly is not an issue.

Then we have the situations where connectivity or causation may initially be an issue, but then no longer is an issue. What is the CM's justification for not allowing the Commission to initiate its investigation after a Coroner's report has been released? Even if Council were to have the Commission apply the CA's narrow interpretation of Section 810(d), in those limited instances where causation is not immediately known, causation will become known to the Commission through a Coroner's report long before they are provided a criminal casebook by RPD. There is no rational justification for the CM's directive not allowing the Commission to initiate its investigation after the Coroner has established cause (sometime between two and three months after the incident) as opposed to forcing the Commission to wait for the completion of a criminal casebook (average delivery time of casebook to date is seven months).[18]

Of course, having the Commission wait to initiate its investigation until the turnover of a criminal casebook presumes there is a criminal casebook to wait for. The plain reading of Section 810(d) requires Commission investigations in instances where the death arose from or was connected with an officer's actions. Nothing in this section limits the Commission to investigate only deaths where the officer's activities expose them to criminal charges. What if the officer was negligent in the operation of a police vehicle and hit a pedestrian while looking down into their mobile computer? To take it one step further, what if the officer wasn't negligent, but was the victim of a third party's negligence when the third party ran a red light and broadsided a police car transporting a prisoner who was killed as a result of the collision?

Under Sections 810(c),(d), and (g), the Commission is obligated to investigate the deaths to determine if the officer involved was following RPD policy and procedures. (Was the officer driving distracted? Was the prisoner seat belted in the back?) As a result, it may be looking at making

policy recommendations. In some situations, there may or may not be a criminal book for the Commission to wait for and they may be waiting for the Internal Affairs ("IA") casebook. The IA casebook takes longer to prepare and is generally five months later than the criminal casebook (average time from incident to delivery of the IA casebook is 12 months).[19]

The CM's directive is an attack on the Commission's OID investigation policy with the net effect that the Commission cannot capture information while it is still fresh, but now must wait until many months later (later than even the CA's narrow interpretation would provide). This directive's effect is contrary to the usual and customary practices for a good investigation, especially when the timing of its launching is within the control of the party seeking to conduct the investigation. No reasonable justification has or can be provided to cause the Commission to wait more than six months (long after memories have started to fade and contact trails have time to go stale) before it can act, as it is duty-bound to do under the Charter.

It is the Commission's request for Council's guidance as to whether the CM's directive, which is currently being applied by staff to all OIDs, even clear-cut OISs,[20] should be modified so that it doesn't unnecessarily impair the Commission from performing its duties when an officer's connection with and / or causation of the death is readily apparent or later becomes so.

Conclusion

The Commission is concerned that the CM's directive of September 3, 2008 is unclear and, in some instances, impairs the Commission's Charter-based duties and obligations to conduct timely, independent investigations of OIDs. The Commission respectfully requests your guidance on these issues for the concurrent benefit of the Public, the City's policymakers and staff, and the Commission.

Regardless of the varied positions the members of the Commission have taken on these issues, every member of the Commission is united in the belief that they would like to see these issues addressed and resolved once and for all so all parties can move on.[21] The Commission will make itself available to answer any questions or provide insight, at your request.

Respectfully,

Brian Pearcy
Chair, Community Police Review Commission

cc: CPRC Commissioners
Kevin Rogan, CPRC Manager
Brad Hudson, City Manager
Greg Priamos, City Attorney
Russ Leach, Chief of Police

[1] Eight Members present: Yes-Beeman, Brandriff, Pearcy, Santore, Soubirous, Ward / No-Hubbard, Rotker

[2] Seven Members present: Yes-Beeman, Brandriff, Pearcy, Ward / No-Hubbard, Rotker, Santore.

[3] The relevant history is being included to ensure the issues are placed in the proper context.

[4] The first OID that fell under the Commission's purview occurred on June 10, 2001 (01-086, Phaisouphanh). The Commission did not get the criminal casebook until over seven months later (January 19, 2002). A review of the Commission's minutes, along with the Chair's recent inquiries to the then Executive Director, past Chair and past Chair of the Investigator Guidelines Policy Recommendation Committee, indicates that the Commission back in 2002 was very dissatisfied by the time delay in getting information regarding the OID. After multiple Commission meetings and discussions that included presentations by RPD, RCDA, and the Coroner's Office as to timing, protocols, and the like, the Commission directed staff to enlist the services of the Commission's investigator as soon as practical. The concern expressed was the loss of evidence (witnesses and memories) due to the passage of time and the goal was to ensure the Commission conducted a thorough and comprehensive independent investigation. This protocol was initiated with its second OID (02-124, Munoz, November 17, 2002) and has been refined in every OID thereafter.

[5] At the Commission's direction, staff established the following procedure for OIDs: After a death that reported to be connected with the action(s) of an RPD officer was published in the local newspaper, Staff was to notify the Commission's investigator and ask them to commence an investigation immediately. The investigator scheduled their arrival on the scene based upon their availability. This process allowed for a built-in delay of any Commission presence or action of at least one business day after the incident. (In practice, the delay may be even longer due to other factors, for example, if the incident occurred over a weekend or the investigator was not immediately available.) This ensured everyone that the Commission's investigator did not arrive until well after the crime scene tape was down and all law enforcement investigators had left. The rationale was that the Commission's investigator was in a public place (where he had every right to be) based on public information and could conduct the Commission's business without the concern of being accused of interfering with an official law enforcement investigation.

[6] Since 2002, there have been no recorded complaints to the Commission or staff of any alleged interference by the Commission's investigator from any law enforcement agency. In fact, there has been at least one occasion where the Commission's investigator has identified and located witnesses overlooked or not identified by RPD. The Commission promptly turned over the contact information and statements of these witnesses to RPD.

[7] While the issue of the whether the CA has an inherent conflict of interest in determining the Commission's scope of authority in OIDs has been raised and remains unanswered, this issue is outside the scope and intent of this letter.

[8] While the issue of the legitimacy of the CM's actions with staff, in relationship to its impact on the ability of the Commission to operate independently of the influence of the CM's office has been raised and remains unanswered, this issue is outside the scope and intent of this letter.

[9] It came to the Commission's attention in August 2008 that its six-year-old OID investigative protocol was not in writing. (Due to the passage of time and changes in personnel – staff and commissioners – everyone, including staff, had assumed it was.) However, it was determined that the sub-committee of 2002 never completed the task of preparing written policies and procedures relating to investigations of OIDs, only of citizen complaints regarding officer misconduct. The Commission's custom and practice over the past six years had become a de-facto policy. Putting the de-facto OID policy in writing became one of several items to be addressed by the Commission's newly-formed Ad-Hoc Committee on Protocol for Investigation of Officer Involved Deaths ("Ad-Hoc Committee"). The CM's directive of September 3, 2008 was communicated to the commissioners and the Ad-Hoc Committee the day before they were to scheduled to meet to address this item on September 4, 2008.

[10] Since the inception of the Commission, there have been 14 deaths classified as OIDs. In 13 of these 14 instances, causation was immediately known as they involved OISs.

[11] In one death (05-091, Rabb), the cause of death was not immediately known, but it fell under the Commission's purview because the death occurred "in connection with the actions of a police officer." (On October 2, 2005, there was a struggle and use of force by police officers to gain compliance and handcuff Mr. Rabb, who was in diabetic shock and was resisting efforts by emergency medical personnel who were on the scene to treat him.)

[12] The most recent incident that brought this issue to the forefront of the Commission was a matter referred to as "Pablo" wherein there were published reports indicating that on July 11, 2008, Mr. Pablo, after being initially detained by RPD officers at around 2:30 PM, was determined to be suffering from a medical issue and officers summoned emergency medical personnel to the scene. He was transported by emergency medical personnel to Riverside Community Hospital shortly before 3:00 PM and died there shortly before 4:00 PM the same day.

[13] There is and remains an open question as to whether the Commission has the power and ability to interpret the meaning and application of Section 810(d). This issue is outside the scope and intent of this letter.

[14] The Rabb incident fell under the Commission's purview as a non-OIS related death occurred "in connection with the actions of a police officer" that was investigated promptly by the Commission. Many members of the Commission and the public have opined that, like the Rabb case, the Pablo incident would be appropriate for a Commission investigation regardless of the cause of death, as the last persons (outside of medical personnel) to have contact with Mr. Pablo were RPD officers and under a plain language reading of Section 810(d) that the Pablo matter should be before the Commission to ensure that the officers conduct was within policy.

[15] To further illustrate the fact that a Coroner's Office cause of death determination is not an appropriate threshold for the consideration of the Commission's involvement, consider the potential case where the cause of death is listed as due to the "blunt force trauma" of a car accident. If a police officer's vehicle were not a part of the collision, then there would be no reference in the Coroner's report that a police officer was involved in the death. However, if the person that died was a pedestrian or the operator of a motor vehicle that was struck by a vehicle that was operated by an individual that was being pursued by (or is alleged by someone to have been pursued by) a police officer, then such a death would be "in connection with the actions of a police officer" and fall under the Commission's purview.

[16] In the Pablo matter, the incident occurred on July 11, 2008. The Commission was not briefed on the Coroner's Office's official cause of death until over two months later. (September 24, 2008 it was reported to the Commission that the Coroner's Office had determined that Mr. Pablo's cause of death was "natural causes.")

[17] That was the action taken by the Commission in the Pablo matter on August 13, 2008, when a Majority of the Commission directed staff to have its investigator conduct a preliminary investigation only.

Eight Members present: Yes-Beeman, Brandriff, Pearcy, Santore, Ward / No-Corral, Hubbard, Rotker

In a compromise to address the differing Commissioner concerns over the CA's interpretation of 810(d), the investigator was to identify, locate, and contact witnesses to the incident only. The investigator was authorized to get statements of any witnesses to preserve their recollection of their observations, if any, and to obtain their contact information if further contact was needed in the future. No written report was authorized. It was also agreed that no report was to be provided to the Commission until after there was an official report from the Coroner's office and it established that an officer caused Mr. Pablo's death or that an officer's actions were a contributing factor to his death.

[18] Of the 12 OIDs in which criminal casebooks have been provided thus far, 1 casebook was provided in month 3, 1 in month 4, 1 in month 5, 2 in month 6, 1 in month 7, 2 in month 8, 2 in month 9, and 2 in month 10.

[19] Of the 12 OIDs in which Internal Affairs casebooks have been provided thus far, 1 casebook was provided in month 6, 1 in month 7, 1 in month 8, 1 in month 9, 2 in month 10, 1 in month 11, 1 in month 12, 1 in month 13, 1 in month 15, 1 in month 19, and 1 in month 25.

[20] Since the directive was put into effect on September 3, 2008, there have been two OIDs that were OISs (08-037, Quinonez, 9/1/2008, and 08-042, Sanchez, 9/11/2008). As this letter is being drafted, there was an in-custody death, (Acevedo, 10/31/2008), that has yet to be classified by the Commission as on OID, but based on the facts set forth in RPD's briefing to the Commission on November 5, 2008, it likely will be.

[21] The issues referenced in this letter (especially in footnotes 7, 8, and 13) are a source of ongoing discord for the public (as evidenced by their comments directly to the Commission and through the press) and for the Commission itself (as evidenced by the varied and passionately held and expressed opinions within). The Council is encouraged to seek the guidance of an independent expert to analyze, discuss, and address these legal and policy issues. A resolution of these issues is needed for the Commission to operate effectively in the future. A continuing failure to provide guidance leaves the wounds that have been created to fester unnecessarily and does a disservice to the community and every member of the Commission that donates so many hours to the City.